Naval Hospital Oak Harbor Prime Health Center
Two Month Well Child Visit

Date:
Time:

Provider Note

Interval History:

Past Medical History:

Medications:
Allergies:
Immunizations:
Family/Social History Update:

Development: ❒ Tracks to midline ❒ Coos/vocalizes ❒ Smiles
❒ Lifts head when prone ❒ Regards face

Physical Exam

Vital Signs ❒ N/A Pain: ___ (0-10)

Weight: _____ kg _____ lb _____%ile Temp: _____ HR: _____
Length: _____cm _____ in _____%ile RR: _____ O2 Sat: _____
OFC: _____cm _____ in _____%ile

Nl	Abn	
❒	❒	General Appearance:
❒	❒	Head:
❒	❒	Eyes
❒	❒	ENT:
❒	❒	Neck:
❒	❒	Chest:
❒	❒	Heart:
❒	❒	Abdomen:
❒	❒	Genitals:
❒	❒	Musculoskeletal:
❒	❒	Skin:
❒	❒	Neuro:

Newborn hearing screen results: ❒ pass ❒ refer
Metabolic screen (2nd) results: ❒ neg ❒ pos ❒ pending

Assessment

Plan

Anticipatory Guidance
Immunizations: DTaP, IPV, Hib-HepB, Prevnar
Other:

Follow-up: 4 months of age other: _____

Addressograph

_____
Examiner's Signature/Name Stamp

Two Month Well Child Visit
Parent Questionnaire

1. Describe your baby's diet:
   - ❒ Breastfeeds _____times per day.
   - ❒ Formula feeds_____ounces per day. Name of Formula:_____

2. Describe your baby's elimination pattern:
   Stools (how many, appearance): Urine (# wet diapers/day):

3. What position do you put your baby to sleep: ❒ Back ❒ Side ❒ Stomach

4. Who is your baby's main caregiver?

5. Do you have any concerns about your baby's hearing or vision? Yes/No

6. Are you aware of the risk of infant botulism if honey is given to an infant? Yes/No

7. Are there any smokers in the household? Yes/No

8. Is there is a gun in the home? Yes/No

9. Does your home have working smoke detectors? Yes/No

10. Do you put the crib rails up whenever you leave your baby in its crib? Yes/No

11. Do you ever leave your baby alone on tables or beds? Yes/No

12. Do you ever drink or carry hot liquids when holding your baby? Yes/No

13. Does your baby ride in a car seat in the back seat, facing backwards? Yes/No

14. Have you checked the temperature of the hot water where you live? Yes/No

15. Do you fear for the safety of yourself or members of your family? Yes/No

16. What questions do you have for your baby's provider today?